Ambulance Company
Submit With Invoice
TYPE OR PRINT

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PATIENT TRANSPORTATION ORDER

Form #: _____

Ambulance Invoice #: _____

DATE: AMBULANCE _____ AMBULETTE _____ EXTRA ATTENDANT YES____ NO____ AUTHORIZED WAITING TIME # OF QUARTER HOURS: _____

IENT'S NAME: _____

M____ F____ D.O.B.: _____ SS#: _____ MIS#: _____ / _____ LEGAL STATUS: VOL____ INVOL____

LOCATION OF ORIGIN OF TRIP (NAME AND ADDRESS)

PATIENT'S HOME ADDRESS

DESTINATION OF TRIP (NAME AND ADDRESS)

TYPE OF FACILITY: (Check) County Hospital ____ VA Hospital ____ State Hospital ____ Private Hospital ____ SNF/IMD ____ Other: (Define)

PREARRANGEMENTS MADE WITH (NAME): _____ TELEPHONE: _____

ACCEPTING PHYSICIAN (NAME): _____ TELEPHONE: _____

ACCEPTING FACILITY (NAME):

	TIME OF CALL	ESTIMATED RESPONSE TIME	ACTUAL RESPONSE TIME
COMPANY 1	AM / PM _____	_____ MIN	_____ MIN
COMPANY 2	AM / PM _____	_____ MIN	_____ MIN
COMPANY 3	AM / PM _____	_____ MIN	_____ MIN

THIRD PARTY PAYOR: INSURANCE: YES ____ NO ____ MEDI/CAL: YES ____ NO ____ NOT AVAIL: _____

INSURANCE CO. NAME:

ID#: ID#:

DSM III-R DIAGNOSIS: _____ DIAGNOSIS #: _____

ELOPEMENT RISK: YES ____ NO ____ SUICIDAL: YES ____ NO ____

ACTING OUT: YES ____ NO ____ DANGEROUS: YES ____ NO ____

MEDICAL CONDITION? YES ____ NO ____ TREATED? YES ____ NO ____
(IF YES. DESCRIBE) (IF YES. DESCRIBE)

OTHER PATIENT'S RELATED TRIP NUMBERS: TRANSPORTED YES NO NONE

SHORT - DOYLE CERTIFICATION: I hereby certify:

1. That ambulance transportation is authorized as a direct mental health service to transport the patient to and/or from a licensed community health care facility and/or Short - Doyle mental health facility within the county.
2. That the patient does/does not appear to be eligible for Medi/Cal transportation.
3. That there is an open Short - Doyle Clinical record at: _____
4. That the DSM III-R Diagnosis is the primary basis for the decision to transport.

SIGNATED SIGNATORY AND TITLE: CONTROL UNIT #: _____

PHYSICIAN REVIEW: DATE: _____ CONCUR AND AUTHORIZE: _____ DO NOT CONCUR: _____

CONTROL UNIT #: